THE PEW CHARITABLE TRUSTS

2005 Market Street, Suite 2800 215.575.9050 Phone
Philadelphia, PA 19103-7077

901 E Street NW 202.552.2000 Phone
Washington, DC 20004
www.pewtrusts.org

September 25, 2018

Oregon Legislative Assembly
Joint Task Force on Fair Pricing of Prescription Drugs
900 Court Street NE
Salem, Oregon 97301

Re: Public Comment from the Pew Charitable Trusts
Joint Interim Task Force On Fair Pricing of Prescription Drugs Meeting, September 27, 2018

Dear Co-chairs and Task Force Members,

The Pew Charitable Trusts (Pew) is pleased to offer comments to Oregon's Joint Task Force on Fair Pricing of Prescription Drugs. Pew is an independent, nonpartisan research and public policy organization dedicated to serving the American public. Our drug spending research initiative identifies policies to better manage spending on pharmaceuticals while ensuring that patients have access to the drugs that they need.

Pew commends the Joint Task Force on Fair Pricing of Prescription Drugs for its work on creating transparency for drug prices across the supply chain of pharmaceutical products and would like to offer comments on one approach to bring transparency to drug prices that could lower the cost of drugs for the state.

Require Better Manufacturer Pricing Data Be Reported to Medicaid

Enable Medicaid to secure larger drug rebates by requiring drug manufacturers to confidentially report discounts provided to Pharmacy Benefit Managers (PBMs) and others in exchange for preferred coverage.[1] This transparency measure is intended to help Medicaid ensure that it is not overpaying for prescription drugs.

Medicaid spending on prescription drugs is offset by manufacturer rebates required by federal law and supplemental rebates that states negotiate with manufacturers. Mandatory federal rebates are calculated as a percentage of a drug's average manufacturer price ("federal AMP"). Federal AMP is based on a statutory formula intended to reflect average drug prices paid to manufacturers in the commercial market.[2] This formula, amended in 2010, excludes manufacturer discounts or rebates that

[1] The Pew Charitable Trusts, "Better Data Could Help Medicaid Programs Cut Drug Spending," Drug Spending Research Initiative (July 9, 2018), https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2018/07/better-data-could-help-medicaid-programs-cut-drug-spending.
[2] 42 C.F.R. § 447.504.

are not given to retail community pharmacies ("off-invoice discounts"), such as rebates to PBMs, hospitals, governmental bodies, or outpatient clinics.[3]

Discounting for drug products is significant. In 2017, manufacturers provided $128 billion in off-invoice discounts and rebates, a 28 percent reduction from $453 billion in invoiced drug sales.[4] These discounts and rebates primarily flow to PBMs and are therefore excluded from the federal AMP calculation. However, for drugs not primarily dispensed through retail settings, manufacturers are required to incorporate PBM and other discounts in their calculations of federal AMP.[5] Including these off-invoice discounts and rebates in the federal AMP formula for all drugs would more accurately reflect the prices paid in the commercial market.

State Medicaid programs could require manufacturers to confidentially submit pricing information not included in AMP. With this information, a state could establish its own version of AMP that includes additional discounts and rebates, and use this to calculate a target supplemental rebate payment.

Medicaid preferred drug lists (PDLs) provide states with leverage to require manufacturers to provide additional information on net prices. Putting a drug on the PDL could be made contingent on manufacturer submission of the additional pricing data and offering rebates based on these new calculations.

One streamlined approach to implement this policy would be to require that manufacturers pay a supplemental rebate based on the modified AMP in exchange for inclusion on the PDL. This supplemental rebate would be equal to the state's net costs under its current policy (taking into account pharmacy reimbursement and existing mandatory and supplemental rebates) minus the state's hypothetical net costs if it were reimbursing pharmacies at modified AMP—the true average net cost of the drug—and receiving the statutory Medicaid rebate on that amount.

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[3] Patient Protection and Affordable Care Act, § 2503.

[4] IQVIA Institute for Human Data Science, "Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022" (April 2018), https://www.iqvia.com/institute/reports/medicine-use-and-spending-in-the-us-review-of-2017-outlook-to-2022.

[5] For 5i drugs—medications that are inhaled, infused, instilled, implanted, or injected—an alternate AMP calculation (5i AMP) is used if at least 70 percent of units are not sold through retail community pharmacies. 5i AMP includes sales and associated discounts and rebates to many entities excluded from the standard AMP—including physicians, pharmacy benefit managers, insurers, hospitals, outpatient clinics, and mail-order pharmacies. AMP and 5i AMP are confidential prices, calculated monthly and quarterly. 42 CFR 447.504(d).

Pew has also developed three other policy options that would reduce drug spending, briefly described below:

1. **Require a State Medicaid Inflation Rebate**

In Medicaid, if a manufacturer increases the price of a drug faster than the rate of inflation, it must pay a rebate back to the states equal to the difference between the price increase and the rate of inflation.[6] A state could require a state-based Medicaid inflation rebate, in addition to the federal penalty, in exchange for a manufacturers' products to be eligible for inclusion on the PDL.[7] The state component of the rebate would not be capped at the AMP of a drug. By magnifying a manufacturers' financial liability in Medicaid for large price increases, price growth for all payers may be limited.

2. **Tax Drug Price Increases Greater than Inflation**

Under this approach, the entity selling the product (likely a manufacturer or wholesaler) would pay a tax on the first sale of the drug in the state.[8] The tax would be equal to the amount by which the increase in the drug's price exceeds inflation, offsetting the drug's price increase above inflation. Taxing price increases greater than inflation would address drug spending by either discouraging excessive price increases or generating revenue, which a state could use to offset patient or insurer spending on drugs.

3. **Extend Medicaid or Other Discounted Prices to Corrections Departments**

Sales of pharmaceuticals to state corrections departments can trigger Medicaid "best price" provisions, which entitle all Medicaid programs to purchase the drug at the same price.[9] Because of this, manufacturers may be unwilling to extend discounts to these entities. However, any discounted sales of drugs to 340B-eligble entities, such as safety net hospitals, are exempted from best price provisions. Under Pew's policy proposal, state corrections departments could negotiate voluntary drug discounts with manufacturers for drugs to be purchased through one or more 340B-covered entities.[10] To provide the department leverage in negotiating these discounts, a state could require manufacturers to

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[6] 42 U.S.C. § 1396r–8(c)(2).

[7] The Pew Charitable Trusts, "Use of State Medicaid Inflation Rebates Could Discourage Drug Price Increases," Drug Spending Research Initiative (June 28, 2018), https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2018/06/use-of-state-medicaid-inflation-rebates-could-discourage-drug-price-increases.

[8] The Pew Charitable Trusts, "A Tax on Drug Price Increases Can Offset Costs," Drug Spending Research Initiative (July 2, 2018), https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2018/07/a-tax-on-drug-price-increases-can-offset-costs.

[9] As well as certain other purchasers. 42 U.S.C. § 1396r-8(c)(1)(C).

[10] The Pew Charitable Trusts, "How Correctional Facilities Could Lower Drug Prices," Drug Spending Research Initiative (June 14, 2018), https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2018/06/how-correctional-facilities-could-lower-drug-prices.

voluntarily extend Medicaid pricing to correctional facilities as a condition for inclusion of their products on the Medicaid PDL.

We appreciate the opportunity to comment to the Task Force and commend the state for its attention to the high cost of drugs in Oregon. Should you have any further questions or if would like more detailed information about these policy proposals, please contact me at ireynolds@pewtrusts.org.

Sincerely,

Ian Reynolds
Manager, Drug Spending Research Initiative
The Pew Charitable Trusts
202.540.6512